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STIGMA AND DISCRIMINATION IN HIV COUNSELING AND TESTING SERVICES IN THE PRIVATE HEALTH SECTOR IN GUATEMALA: A QUALITATIVE STUDY

July 2008

This publication was produced for review by the United States Agency for International Development. It was prepared by Olivia Ortiz for the Private Sector Partnerships-*One* project.

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Country Report

Country Report Series: PSP-*One* Country Reports were developed to inform specific PSP-*One* country program operations, but they also contain results that may be of interest to a wider audience. All papers in the series were reviewed by PSP-*One* technical staff in the field and in Washington, DC, as well as by relevant PSP-*One* program management staff.

Recommended citation: Ortiz, Olivia. July 2008. Stigma and Discrimination in HIV Counseling and Testing Services in the Private Health Sector in Guatemala: A Qualitative Study. Bethesda, MD: Private Sector Partnerships-One project, Abt Associates Inc.

Contract/Project No.: GPO-I-00-04-00007-00

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CONTENTS

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CT	HIV counseling and testing
ELISA	Enzyme-linked ImmunoSorbent Assay
FGD	Focus group discussion
FSW	Female sex worker
HIV	Human Immunodeficiency Virus
IDI	In-depth interview
MARP	Most-at-risk population
MSM	Men who have sex with men
NGO	Nongovernmental Organization
PLWHA	People living with HIV/AIDS
PSP-*One*	Private Sector Partnerships-*One*
USAID	United States Agency for International Development

ACKNOWLEDGEMENTS

We would like to thank Eileen Yam and Denise Averbug of Abt Associates Inc. and Meliné Caal, independent consultant, for their valuable inputs.

EXECUTIVE SUMMARY

This document discusses the outcomes of a qualitative study conducted in 2007 and 2008 by the Private Sector Partnerships-*One* (PSP-*One*) project in three departments in Guatemala (Guatemala, Izabal and Quetzaltenango). The objectives of the study were:

1. To describe the knowledge and practices of private clinic and laboratory service providers regarding HIV and HIV counseling and testing (CT).
2. To identify the characteristics of the stigma that private service providers place on female sex workers (FSWs), men who have sex with men (MSM), people living with HIV/AIDS (PLWHA), and issues related to HIV.
3. To describe the experiences of FSWs, MSM and PLWHA with private CT services.

The purpose of the study is to identify actions that can be taken to improve CT services. It is the counterpart of a similar study conducted with public sector users and providers.

The study had a total of 133 respondents. Information was collected in 22 in-depth interviews (IDIs) and 15 focus group discussions (FGDs). Target populations were made up of FSWs, MSM and PLWHA. Private service providers included biochemists working in laboratories, doctors, laboratory support staff and clinic staff.

The findings that emerged from the interviews and FGDs are organized in this report according to the study objectives and interview questions. With respect to providers' knowledge and practices (Objective 1), we looked at issues related to HIV transmission, prevention methods, pre-test counseling, testing and post-test counseling, including how test results are announced to patients. Regarding stigma and discrimination (Objective 2), we identified topics related to general treatment and differences in treatment according to sex, gender or any other condition that may lead to discrimination; we identified the providers' perceptions of reasons why the target population may not use their services; and we inquired as to whether they actually acknowledge providing services to the target population and what opinions they hold regarding FSWs, MSM and PLWHA. With respect to users' experiences (Objective 3), we identified topics related to treatment of users, pre-test counseling, testing itself (taking samples), post-test counseling, confirmation tests and recommendations for health workers.

The most important findings regarding providers' knowledge and practices were that most providers did not identify vertical transmission from mother to child as one of the forms of HIV transmission. They frequently mentioned blood transfusions as an important path of transmission. With respect to prevention in the workplace, the biochemists and doctors displayed greater knowledge of protection and risk of infection than laboratory staff and clinic staff. The latter group showed greater fear of the risk of work-related infection. Most study participants estimated their risk of HIV infection to be high due to their professional activities. Regarding CT practices, it was found that providers do not use a standard protocol. Laboratory staff (particularly biochemists) suggest that the great majority of doctors are not familiar with HIV testing procedures and that many people arrive at the laboratory misinformed. Furthermore, it is apparent that confirmation tests vary according to the patient's budget; some laboratories carry out ELISA (Enzyme-linked ImmunoSorbent Assay) tests as a confirmation of rapid screening tests if the patient cannot afford a Western Blot. In addition, the term "counseling" generally refers to informed consent, general information about the procedure and type of test, information about specialized HIV services and risk-evaluation counseling itself. Moreover, post-test counseling and the delivery of results vary according to the laboratory or doctor and whether the test was ordered by a doctor or was requested by the patient him/herself. If the person is HIV positive, the tendency is to offer some type of counseling or information, provided either by the biochemists (if the test was voluntary) or by the doctor (if the test was recommended). If the results are negative, the tendency is to offer only the results with no additional information. Some laboratories do not offer any information regardless of the result or who requests it. A small group of doctors and laboratory providers identified the need to carry out pre- and post-test counseling regardless of the result.

The findings related to stigma and discrimination on the part of providers indicated that providers do not directly demonstrate stigma or discrimination against the target populations. To some extent, this is because these populations do not appear to use these services frequently. However, discriminatory treatment can be detected indirectly in the form of non-acceptance of these population groups as users; for instance when providers refer to the services of other private facilities, when they express their opinions about these population groups, or when they relate anecdotes about the groups. This supports the statements of users who claim to have received poor treatment and inadequate information when testing positive. Some of the more obvious signs of the stigma detected are: health workers' fear of the disease (PLWHA are categorized as "contagious"); discrimination against FSWs and MSM when providing services due to the risk of damaging the provider's or facility's reputation; the fact that providers expect these groups to hide their sexual or professional identity if they wish to request services; and the belief expressed by the providers themselves that they don't discriminate because they are professionals or that the facility doesn't discriminate because it is a business. Providers who indicated a greater level of familiarity with the target populations tend to express few or no discriminatory attitudes.

The findings with respect to clients showed that for some, the treatment received when using private services (good or poor) depends on whether or not they are identified as MSM or FSWs. The FSWs who said they were treated well generally did not identify themselves as FSWs and used these services as part of their general health care. For both MSM and FSWs, the preference for private services is based on the reliability and speed of the care process and the delivery of results.

PLWHA perceive private service providers to be disrespectful and not properly trained to care for people in their condition, mainly due to the lack of information about what it means to live with HIV and an insensitive approach when giving the diagnosis.

1. INTRODUCTION AND OBJECTIVES

In 2007, the Private Sector Partnerships-*One* (PSP-*One*) project was launched in Guatemala with the objective of improving the quality of HIV counseling and testing services (CT) offered by the private health sector. This sector plays an important role in providing CT services in Guatemala.[1] A significant percentage of the most-at-risk populations (MARPs) – female sex workers (FSWs) and men who have sex with men (MSM) – take HIV tests in the private sector.[2]

PSP-*One* carried out a study to evaluate the stigma and discrimination faced by MARPs who request CT services in the private sector. It was an adaptation of a similar study conducted previously by the Calidad en Salud project in public sector facilities.[3]

This study identified the stigma and discriminatory treatment that most-at-risk populations experience in private health facilities offering CT services in the country. The results of the study will help determine actions that can be specially designed to reduce stigma and discrimination in these facilities. In addition, it will allow for a comparison with the results of the study conducted by Calidad en Salud in the public sector.

The objectives of the study were:

1. To describe the knowledge and practices of private clinic and laboratory service providers regarding HIV and HIV CT.

2. To identify the characteristics of the stigma that private service providers place on FSWs, MSM, people living with HIV/AIDS (PLWHA), and issues related to HIV.

3. To describe the experiences of FSWs, MSM and PLWHA with private CT services.

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[1] Alfaro, Yma, O'Hanlon, Barbara and Averbug, Denise. HIV Testing Services in the Guatemalan Private Sector. (Servicios de Prueba de VIH con Orientación Brindados por el Sector Privado de Salud en Guatemala: Resultados de un Sondeo Rápido). Private Sector Partnerships-*One*. Guatemala, May 2008. Available in Spanish only.

[2] León, Roberto and Larramendi Hawry, Tracy. Anonymous Survey on Health Services: Internal Report (Sondeo anónimo sobre servicios de salud; Reporte Interno). Universidad del Valle de Guatemala, January 2008. Available in Spanish only.

[3] USAID|Calidad en Salud, Guatemala. Health Provider Stigma and Discrimination toward Vulnerable Groups in Guatemala in regard to STI, HIV and AIDS: A study about Knowledge, Attitudes and Practices (Estigma y discriminación relacionados a ITS, VIH y sida de los proveedores de salud hacia los grupos vulnerables en Guatemala: Un estudio sobre conocimientos, actitudes y practices), August 2007. Available in Spanish only.

2. METHODOLOGY

2.1 DATA COLLECTION

To achieve the proposed objectives, both private health providers and the FSWs, MSM and PLWHA who use their services (users) were included in the study.

Data were collected using focus group discussions (FGDs) and in-depth interviews (IDIs) with providers and representatives of high-risk populations, or users (Annex 1: Data Collection Instruments). Providers included doctors, biochemists, private clinic staff and private laboratory staff. The following criteria were used to determine the inclusion of members of each group in the study:

a. Users:

- At least 18 years of age
- Not a participant in the Calidad en Salud study
- Have taken an HIV test in the private health sector

b. Providers:

- Work in the private health sector (and may also work in the public sector)
- Not a participant in the previous Calidad en Salud study

This study was conducted in the three departments where PSP-*One* works: Guatemala City, Izabal (Puerto Barrios) and Quetzaltenango (Quetzaltenango and Coatepeque). Table 1 summarizes the total number of FGDs and IDIs conducted.

The selection and recruitment of users was done mainly through nongovernmental organizations (NGOs) that work with the target groups (FSWs, MSM and PLWHA). Where this was not possible, the research team recruited participants in the places where they gather. For example, in Izabal, the team met with FSWs in a bar where they work.

Different strategies were used to recruit providers for FGDs. The majority of clinic and laboratory staff in Izabal and Quetzaltenango were recruited via invitations and/or direct visits to known private clinics and laboratories. In Guatemala City, clinic and laboratory staff were invited to participate via contact with private doctors who participated in the project's training sessions.

TABLE 1. SUMMARY OF DATA COLLECTION

Population	Guatemala	Izabal	Quetzaltenango
Users: 80 participants (27 PLWHA, 21 FSWs and 32 MSM)			
1. PLWHA	2 FGDs	1 FGD	1 FGD
2. FSWs	2 FGDs	1 FGD	4 IDIs*
3. MSM	2 FGDs	1 FGD	1 FGD
Health providers: 53 (7 D, 19 support staff, 23 laboratory staff, 4 biochemists)			
4. Private clinics			
4a. Doctors	3 IDIs	2 IDIs	2 IDIs
4b. Nurses, counselors, administrative staff	4 IDIs 1 FGD	1 FGD	-
5. Private laboratories			
5a. Biochemists	2 IDIs	1 IDIs	1 IDI
5b. Technicians and administrative staff	1 IDI	1 FGD	2 IDIs 1 FGD
Total			
15 FGDs 22 IDIs	7 FGDs 10 IDIs	5 FGDs 3 IDIs	3 FGDs 9 IDIs

* After several failed attempts to hold a FGD in Quetzaltenango, it was decided to do an IDI with four FSWs from a bar.

To recruit participants for IDIs, the researchers carried out the following activities: visits and/or invitations to known laboratories and clinics and invitations to private health sector staff who had previously participated in PSP-*One* activities. In general, providers were selected using convenience and snowball sampling. Although the initial goal was to carry out IDIs with doctors and biochemists and FGDs with all other respondents, in some instances (such as with FSWs in Quetzaltenango, clinic staff in Guatemala, and laboratory staff in Guatemala and Quetzaltenango), IDIs were conducted in the place of FGDs because not enough participants were recruited for a FGD.

This study was approved by Abt Associates' Institutional Review Board. All participants gave informed consent and their confidentiality and anonymity were guaranteed by the researchers both in FGDs and IDIs.

2.2 ANALYSIS

The questions for the FGDs and IDIs were grouped by topic and findings were classified that way also. Table 2 shows the final organization.

TABLE 2. TOPICS FOR DATA ANALYSIS AND CLASSIFICATION

Providers	Users
Practices and knowledge of private providers	**Experiences with the private sector**
Forms of transmission	Counseling
Prevention methods	Test
Providers' practices	Post-test
HIV services	Request for confirmation test
Counseling	Recommendations for health professionals
Test	
Post-test	
Discrimination	
General treatment and differences in treatment according to sex, gender or other characteristics	Treatment by health professionals
Differences in public versus private practice (why don't FSWs and MSM use private practices)	
Use of providers' services by the target population	
Stigma	
Opinions about target populations	
Others	

3. RESULTS

The findings from the FGDs and IDIs conducted in December 2007 and January 2008 with providers and users of private health providers that do HIV testing are presented below.

3.1 GENERAL STUDY PARTICIPANT CHARACTERISTICS

With respect to users of services, most PLWHA respondents were women (16 of 27) who ranged in age from 19 to 59 years, with an average age of 34. Most had no secondary education, and their marital status varied. The majority of the 21 participants who were FSWs were single, between the ages of 18 and 37 (average age: 25), and they had some or full secondary education. The majority of the 32 MSM participants were single, between the ages of 18 and 33 (average age: 24) and had a secondary education or higher.

With respect to providers, most doctors were male (6 of 7 participants) between the ages of 37 and 57 (average age: 48). They included two obstetrician/gynecologists, two family doctors, a general surgeon, an infectious disease specialist and a naturopath. Most clinic staff who participated were women (15 of 19) between 19 and 49 years of age, with an average age of 37. Their job descriptions varied, but they were predominantly secretaries, receptionists and nurses. There was also a smaller number of administrative staff, supervisors and maintenance workers or janitors.

Most laboratory staff were also women (16 of 23) between the ages of 19 and 49, with an average age of 27. More than half worked as laboratory technicians. Among the biochemists, half were men and half were women, age 23 to 45, with an average age of 33.

3.2 FINDINGS

This section is organized by study objective. The experiences of providers are discussed first, in reference to Objectives 1 and 2. This is followed by the experiences of users, in reference to Objective 3. This section concludes with a table of similarities and differences between the information given by providers and by users.

3.2.1 **OBJECTIVE 1:** TO DESCRIBE THE KNOWLEDGE AND PRACTICES OF PRIVATE CLINIC AND LABORATORY SERVICE PROVIDERS REGARDING HIV AND HIV CT

GENERAL

When asked to describe ways in which HIV is transmitted, the great majority of interviewees did not include transmission from mother to child; that is, while it was sometimes mentioned during the interview, it was not immediately identified in response to a direct question about forms of transmission. Also rarely mentioned was the risk of transmission through shared syringes/needles.

In regard to prevention, biochemists and laboratory staff emphasized the need to prevent transmission via blood transfusions. Repeated comments were made about the risk of infection through blood transfusions and the possibility of receiving tainted blood during the six-month window period after a person is infected with HIV when they may still test negative. *"Even if tests are done in the blood bank, they are only antibody tests. That means we only know the donor doesn't have antibodies yet, but we don't really know if the donor is infected and is in the window period. In that case, what would need to be done is to implement antigen testing in blood banks" (Biochemists).*

As for prevention in the workplace, biochemists and doctors had more knowledge of protection and prevention measures to avoid accidental infection than did clinic and laboratory staff.

Pre-test counseling was often confused with the request for informed consent, especially in the case of laboratories. Not all laboratories or health facilities request informed consent, although most do: *"Patients arrive and they don't know why they are having the test done" (Laboratory staff).*

Similarly, there is no uniform testing protocol.[4] This is most apparent when doctors or other clinic staff request the test or carry it out. There is also variability in giving results and post-test counseling. Perhaps the only point of convergence among all interviewees is that those who test positive are referred to a specialized center (generally in the public sector), although some facilities seal results in an envelope and give them directly to patients who were tested voluntarily, without offering any type of counseling service.

The information that the person in charge of the laboratory gives HIV positive patients about where to obtain advice regarding medical care is generally called "counseling". Doctors perceive counseling as emotional support rather than education and prevention. There is very little discussion of counseling about high-risk behaviors or specialized counseling for PLWHA, and no mention of a risk assessment of behaviors that may have led to exposure. In fact, providers do not even know if the person is a FSW, MSM or PLWHA. Similarly, providers think that post-test counseling should consist of emotional support, and they do not feel they have the appropriate training to offer this kind of service.

Some laboratory staff point out the need for specialized counselors. Patients whose results are negative rarely get follow-up and counseling – how to avoid risky situations and continue behaviors that have allowed them to remain HIV-free – which has implications for the reduction of high-risk behaviors.

Within the private sector, counseling is considered to be the doctor's responsibility, but often no such counseling is offered; if it is offered, the patient often fails to understand what test is going to be done and why. While most facilities request informed consent, some patients may not have given their permission, and laboratories do not ask for it since they have the doctor's requisition. Some private doctors do not request consent, feeling they may make patients uncomfortable by suggesting a test, or they simply do not insist on testing, as in the case of the private obstetrician/ gynecologists who leave the decision up to the patient. This situation may indicate a stigma associated with requesting a test and possible repercussions for the doctor's office. It should be pointed out that none of the staff interviewed identified themselves as counselors, but rather

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[4] Ministry of Public Health and Social Assistance. Guidelines for the Orientation to STI, HIV and AIDS (Lineamientos para la Orientación en ITS, VIH y Sida). Guatemala, December 2005. Available in Spanish only. Ministry of Public Health and Social Assistance.
Manual for the Orientation and Management of Emotion of People Living with HIV and AIDS (Manual para la Orientación y manejo de las emociones en personas que viven con VIH y Sida), Guatemala, December 2005. Available in Spanish only.

perform this task as part of their other responsibilities. This may be why no consistent or structured practice was observed.

BIOCHEMISTS

Of the four types of providers interviewed, this group is perhaps the best-informed regarding transmission, prevention, counseling procedures, testing and current legislation: *"In general, the rate of work-related accidents is around 0.07% or 0.09%, more or less. In comparison with hepatitis B, it's pretty low" (Biochemist).*

Like laboratory staff, this group places a great deal of emphasis on transmission via blood transfusions. It may be the group that is closest to the HIV epidemic in terms of possible contact with at-risk populations, with the public health system in Guatemala, and with the most recent developments on the topic. It seems that study participants from laboratories in the country's interior have a slightly broader understanding of the topic than do participants from Guatemala City. Perhaps this is because they also contract to provide services to the public sector. During the study FGD and IDI, these were the participants who went into the greatest detail with respect to counseling and who may have to carry out multiple duties given the workload that results from the demand for services and the limited supply of providers in their areas.

LABORATORY STAFF

This group of participants seemed to be the second most informed about CT procedures. However, some participants in this group do not clearly understand the pre- and post-test counseling process. They know it exists, but consider it to be the responsibility of the biochemist, especially in the case of positive results.

As for transmission and risk of work-related infection, they have limited information in many cases. As with clinic staff, though to a lesser degree, this group considers itself to be at high risk for infection depending on their job in the laboratory (e.g. a technician who takes samples vs. a receptionist or worker). They have basic concerns about infection via casual contact with people and their body fluids: *"… at least if there's urine or something like that and I get infected with urine, I don't know if it can be transmitted that way as well …" (Laboratory staff).*

Regarding the test itself, some laboratories offer an ELISA (Enzyme-linked ImmunoSorbent Assay) or Western Blot test to confirm initial test results, depending on the patient's budget. It seems that the confidentiality of test results may be a problem, especially in provincial areas where it was mentioned that MSM prefer not going to private facilities in order to avoid becoming the subject of talk.

At the same time, there are pre-established norms for delivering results: patients who test positive must speak with someone while those who test negative are given their results immediately and are allowed to leave. This difference indirectly yet explicitly tells laboratory staff and other users about an individual's HIV status.

DOCTORS

This group's knowledge and understanding of HIV varies widely. The respondents ranged from an infectious disease and HIV specialist who works in both sectors (private and public), to a naturopath from the private sector who owns an alternative therapy business and reports a great lack of basic knowledge about HIV transmission and prevention. All of the doctors except the naturopath know about the basic forms of transmission and prevention. Like the rest of the study participants, doctors almost never mentioned transmission from mother to child or by sharing needles or syringes. The two obstetrician/gynecologists did not mention it directly when asked, although later they did say they suggest HIV tests to their pregnant patients. The lack of up-to-date prevention information was also detected in the case of a doctor outside the capital who suggested the use of condoms with nonoxynol-9: *"There has always been a condom with a lubricant that has "monoxibil" [nonoxynol-9] but I don't know if there's another one that's better" (Doctor).*

Responses regarding CT are mixed. Two of the seven providers conduct risk assessments, request consents and explain the test to the patient. Some providers talk about the stigma related to asking for an HIV test and say that their patients do not look favorably upon post-test counseling or feel uncomfortable if the doctor requests a test: *"…I don't suggest it directly, because they sort of see it negatively. In this case I said: "Look, I have to do some sexual transmission tests", and give him the requisition" (Doctor).*

CLINIC STAFF

This is the group that is the least informed about HIV CT procedures. Although the places where they work often report that they do not offer HIV services, they do conduct testing; it is the clinic staff who take samples or who occasionally find themselves in the position of having to give test results or to look after infected people: *"then we started to talk to the lady, to tell her, to talk to her and give her God's love more than anything, so that she can ask God to heal her and give her peace, because it's a really difficult thing" (Clinic staff).*

This group seems to worry the most about the risk of HIV infection, but they are also the least informed of all the groups in this regard. They mentioned precautionary measures such as being very careful with everything, or they reported excessive measures based on the so-called universal precautions, which they do not recognize by that name. It appears that in the private sector the focus is on good customer service and management rather than on specific training about proper prevention measures for dealing with HIV positive patients.

Finally, it is surprising to note that the majority of medical providers and clinic staff do not recognize that they offer HIV services. In other words, they do not think they are providing an HIV service when they conduct testing and refer patients who test positive to specialized HIV treatment services. However, the great majority do conduct HIV testing. The case of the naturopath who requires HIV tests of anyone who requests her services and yet has limited knowledge of forms of transmission and how to manage and give results may be cause for concern.

3.2.2 **OBJECTIVE 2:** TO IDENTIFY THE CHARACTERISTICS OF THE STIGMA THAT PRIVATE SERVICE PROVIDERS PLACE ON FSWs, MSM, PLWHA AND ISSUES RELATED TO HIV

GENERAL

It seems that the provider groups interviewed have very little known contact with people in the MARP. The vast majority reported that they cannot tell if someone is a FSW or MSM. As for PLWHA, providers mentioned cases they identify via a positive test result or patients who occasionally come for private appointments, as well as individuals whom the providers know through different circumstances but who are not their patients.

In general, this group reported individual anecdotal cases when talking about their personal experience with the target populations. Topics related to stigma and discrimination are thus more easily observed in providers' opinions of the target populations.

OVERALL TREATMENT AND DIFFERENCES IN TREATMENT ACCORDING TO SEX, GENDER OR OTHER CHARACTERISTICS

This section summarizes the differences in how the target groups are treated in public and private sector facilities. The interviews did not address the topic systematically and many private providers had limited or no experience with these groups. The few comments we obtained had to do with the possibility of better service and care in the private sector since staff have more time, the services are paid, or the services are more personalized.

Nonetheless, it is important to mention that some providers, especially doctors, pointed out that the public sector is better organized and has better resources to deal with HIV-related issues, including specialized counseling, confirmation tests, access to treatment, and familiarity with the topic and with the affected populations.

When providers were asked directly if there are differences in the way the target population is treated, all immediately responded that there was no difference or that there was no reason for differences to exist: *"We let them know what the rules are here. Treat the patient well, don't discriminate, no matter if it's the poorest patient or the one who has money, or whether they're homosexual, no matter what they are, they're treated equally" (Laboratory staff).*

Most study participants, particularly those who work in laboratories, assume that everyone is a carrier of HIV and that they must take the necessary precautions. Some said they are more careful or take more precautions when they know the person is HIV positive or when they are told the test is to detect HIV. One participant said that more care should be taken when dealing with homosexual patients. In some cases, participants spoke hypothetically when they said patients should be treated equally, since many indicated that they do not deal with the target populations or reported very isolated cases of contact with people from these populations. In such cases, they claimed to give the same treatment to these patients as to any other.

PROVIDERS' OPINIONS ABOUT TARGET POPULATIONS

Female Sex Workers

Biochemists and laboratory staff seem to be more familiar with this group than doctors and clinic staff. Some study participants expressed understanding and even empathy towards this group. Others were disapproving, while some expressed resignation or used technical terms to express their opinions about sex work. The majority of participants identify these women as one of the most exposed or at-risk groups for being infected with HIV. In terms of **understanding and empathy,** providers pointed out that women engage in this activity out of necessity, that they have limited opportunities or insufficient education to work in other areas, that some are immigrants, that they have suffered different kinds of abuse and that they should not be judged: *"I feel really sad for them, I pity them to put it one way. Maybe they weren't raised in a family with a father and a mother, like we were. What do we know? I imagine that's why they left and decided to take another path, who knows." (Clinic staff).*

Some participants consider this group to be more informed, more conscious and more protected than housewives since they can negotiate the use of a condom. One participant said they fulfill an important social function since there is less sexual aggression towards other women thanks to their services. **Disapproval** was expressed through comments such as FSWs are ignorant, they are a source of infection, and they engage in this activity because they don't want to do anything else. Some participants think that FSWs don't protect themselves or don't know how to protect themselves, that they expose themselves deliberately and that they don't use protection because they make more money that way. Others feel that people are more exposed to the disease due to prostitution and that the health system does not have adequate controls. Some comments also suggested it is an immoral activity and that these women damage the reputation of private clinics, offices, and the doctor himself when they request services: *"A normal patient is welcome in the clinic, but if it's really obvious that, how can I put it, it's embarrassing to have them in the waiting room, then […] it's embarrassing to have a sex worker in the waiting room with the other patients. They think poorly of the doctor who sees her" (Clinic staff).*

Those who indicated feelings of **resignation** think that the situation is inevitable, that it is a deeply entrenched activity, that it is one of the oldest trades in the world and that this group should be informed, educated, etc. The technical comments refer to a high-risk group that should be protected since their activities make them more susceptible to infection.

An important difference was made between "institutionalized" and independent FSWs. Institutionalized FSWs are those who work in bars, and who were reported to have weekly check-ups in clinics as well as work permits. Independent FSWs are those whom participants call "illicit", referring to a variety of women such as immigrants, housewives and women working in bars who become infected with HIV and are forced to move to other locations in order to continue working anonymously. These women often use private services without identifying themselves as FSWs: *"Because a lot of female sex workers come here and they come in like any other person, no one discriminates against them here" (Doctor).*

Men Who Have Sex with Men

Of the three groups, this seems to be the one that is judged the most severely, although there were some study participants who refrained from expressing an opinion, some who mentioned the psycho-social causes of homosexuality, some who pointed out their greater degree of visibility, and some who felt that this group is informed and takes precautions. When talking about MSM, participants included both homosexual men and men who have sexual contact with other men, whom some called "bisexual". Only one participant mentioned transsexuals, and the information does not allow us to determine whether participants also implicitly refer to transsexuals when they talk about homosexuals. The greatest disapproval was observed when the topic of homosexuality was addressed directly; participants said little about bisexuality.

In terms of **disapproval,** participants expressed opinions that homosexuality is unnatural, immoral, unacceptable and responsible for infecting women through bisexual activity. Clinic staff emphasized the religious aspect and the transgression that homosexuality implies: *"For me, it's dirty. […] men with men because God didn't command it, I think it's against the laws of God" (Clinic staff).*

Some participants consider themselves to be at risk when they work with this group. They also consider homosexuals to be uninformed and promiscuous, and some consider them to be the main source of HIV transmission. Disapproval was expressed as much towards homosexuality among men as among women. Some participants also said that homosexuals corrupt youth and are associated with pedophilia. Some said that they felt sorry for this group.

Those who **remained neutral** reported that it is a matter of taste; each person is free to do as they please. Some said that it is not homosexuality but rather promiscuity that causes infection. Some **psycho-social aspects** that were reported to explain homosexuality include dysfunctional families, violence and abuse. Others emphasized that homosexuality is becoming fashionable, that it is seen more frequently and that young people express it openly. Comments were also made recognizing this group as **informed**. Others said that homosexuality is a culture and should be respected, and that this group includes respectable people who use protection and who should not be discriminated against. Still others pointed out that although they take precautions, MSM are at risk because they have sex with transsexuals.

On the whole, doctors and clinic staff seem to indicate the greatest amount of disapproval towards this group, although it should be pointed out that two doctors did not indicate any prejudice or discrimination, but rather tolerance and respect: *"They're human beings just like the rest of us. There's no difference, for me there's no difference in that sense with patients" (Doctor).*

People Living with HIV/AIDS

In general, participants tended to express empathy towards PLWHA and to say they behave responsibly. On the other hand, they made certain negative comments related mainly to the painful nature of this condition. A few participants expressed rejection, although PLWHA is the group that received the fewest comments of this kind.

In terms of **empathy**, participants commented that no matter what the source of infection, these people need support and should have access to treatment and medications, and that they should be treated with affection rather than discrimination. Some emphasized that living with PLWHA does not mean that HIV will be transmitted to other household members, and that with treatment they can lead a normal life: *"Well, I would consider them to be normal people who can continue to go* *about their business; working, growing, being aware that they have to avoid spreading the disease, and not isolating them" (Doctor).*

This group is considered to have the same rights as any other person. Similarly, they are considered to be **responsible** in the sense of caring for their family and their partner and preventing new infections. One exception to this, and which generates disapproval, are people who know they have HIV yet continue to have sex, as is mentioned in the case of illicit FSW. Some respondents said that people with HIV should abstain from sex.

The **negative** comments that the study participants expressed were related to the fear and sadness generated by this group and the perception that they have been given a death sentence. Participants admitted that these people are discriminated against socially. **Rejection** is focused on those who hide their HIV status and who may be causing new infections, or those who refuse to be tested. PLWHA are considered to be sources of infection. One doctor indicated that PLWHA receive the greatest amount of discrimination and that nothing can be done to change the minds of health care providers who have prejudiced attitudes. Others think that PLWHA are marked by stigma for the rest of their life, or that even with treatment there is no way to comfort the patient since they will never be able to lead a normal life.

Although empathy was expressed towards this group, specific cases of PLWHA that were mentioned show that providers fear becoming infected and step up universal precautions in order to prevent infection. Participants told stories of medical staff who were infected while assisting someone in a car accident on the highway, and some participants ask for detection tests before coming into physical contact with their patients. Others emphasized that their clinics do not accept new patients who are HIV positive though they do care for patients who have been regular clients, who became seropositive over the course of time, and whose doctor continues to see them. Doctors and biochemists reported having had greater interaction with PLWHA than did clinic and laboratory staff.

DISCRIMINATION

The topic of discrimination was directly addressed with providers by asking them if they thought that target populations were discriminated against, either in their own facility or elsewhere.

Responses varied from denial of discrimination in the facility to admission that it exists. Some claimed that there is no discrimination in the health facility, particularly among health care professionals, because they are trained and have had sufficient exposure to the topic to deal with all kinds of people. In other words, they are professionals: *"(…) At the professional level, no, never. I don't think so, we're professionals" (Biochemists).*

Some also said that there is no discrimination in private facilities because they are businesses, and thus quality customer service does not allow for these kinds of attitudes. Laboratory staff tended to report that their facility does not discriminate but that they know of others that do. There were also reports of third parties (colleagues) who are afraid to work with PLWHA. Some laboratory staff reported discrimination in the medical setting, which could suggest that they think it doesn't exist in the laboratory but does exist in health care.

Among clinic staff, some admitted that discrimination exists due to ignorance about the disease. They also admitted that there may be some discrimination against FSW or MSM when they are easily identifiable, and that these patients may feel uncomfortable when other people display disapproval of them. They pointed out that this type of client could damage the reputation of the laboratory or clinic. Those within medical practices who are more familiar with these populations and particularly with PLWHA indicated that discrimination does exist towards this population and that it is very obvious: *"In general, I think that homosexuals or prostitutes are not discriminated against anymore. Now, discrimination is basically aimed at patients that test positive for the disease, where there is still a lot of discrimination" (Doctor).* Comments were made that suggested rejection of these populations on the part of doctors as well as secretaries who are responsible for triaging patients. There is both a belief that this attitude will not change no matter how much training people receive, and a sense of confidence that educating medical providers about these populations and the topic of HIV in general can help reduce stigma and discrimination. More generally, participants talk about the social perception that the media discriminate against these populations, or that some news stories report that private facilities deny services to people with HIV.

3.2.3 **OBJECTIVE 3:** TO DESCRIBE THE EXPERIENCES OF FSWs, MSM AND PLWHA WITH PRIVATE CT SERVICES

GENERAL

FSWs and MSM alternate between using private, public and NGO facilities; their choice to use a private service likely depends on their experiences with each sector. PLWHA who used private services earlier in their illness do not return since most receive treatment in public hospitals or clinics and NGO facilities.

Both MSM and FSWs stated that they used private services for their first tests due to a lack of knowledge about public services or NGOs, as well as the lack of non-private services in their area. Once informed of other options for subsequent tests, they prefer public and NGO services and return to private services only when they have money available and/or need a faster result: *"After going to a place like ASI*[5]*, well, they're more friendly and that makes all the difference. After going there, now I wouldn't have it done in a private clinic" (MSM).* Some individuals in these groups prefer private services, because they lack trust in the reliability of the public sector. They say that the public sector mixes up tests and gives wrong results, both false positives and negatives, and that the process of testing and analysis is slower; they find private services to be more efficient. Some FSWs use private services for a variety of health problems and therefore also take an HIV test there, especially when they need a quick result. This group points to confidentiality on the part of private doctors as an additional advantage.

In summary, the factors that determine MSM and FSWs preference for private services are: test reliability, ease of access to the service, confidentiality and speed of service.

PLWHA used the private sector early on, when they went to a private laboratory as the first part of the care process. Since receiving the first positive diagnosis, they moved between sectors: They went from a private laboratory to a private doctor's office, to an NGO (often Proyecto Vida), or were sent to the Roosevelt Public Hospital, to other private laboratories to confirm the results, and finally to Clinic 12 (a public sector HIV/AIDS treatment clinic in Quetzaltenango).

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[5] A local NGO that specializes on HIV/AIDS care.

TREATMENT

None of these clients gave much information about the care process. Various groups of respondents commented that private services are limited to taking the sample and giving results without any more interaction than is strictly necessary. However, their stories, included comments from which it was possible to intuit that they felt they were treated differently, and discriminated against.

Among both FSWs and MSM, there is a notable relationship between their appearance (which makes then recognizable as FSWs or MSM) and the treatment they receive: *"in the private clinics, when they see that someone is homosexual or has a different sexual orientation, there's always rejection, even though the service is being paid for. It's as if they don't pay as much attention; they're very abrupt. You would think that if someone's paying for a service it's so that they're treated well" (MSM).* Two positions emerged from the discussions with both FSWs and MSM. The first is of those who believe that receiving good treatment depends on the amount of respect each patient has for him/herself and on the attitude that he/she takes when seeking care; their behavior determines whether they receive good or poor treatment from private laboratory or clinic staff: *"Sometimes it depends on the woman herself whether the doctor or the laboratory staff treats her well. Because if you're humble, you see, even though you're paying, they treat you well. But if you're obnoxious, and say this and that, who knows what; then they get mad, that's why they treat you badly" (FSW).* The other position is that appearance should not matter and poor treatment should not be allowed when a service is being paid for and when patients have the right to demand good treatment. Some MSM noted a change in treatment when they admit they are gay, and have even received counseling from people who attempted to change their way of thinking and being.

For FSWs, the likelihood of receiving good or poor treatment is also determined by whether or not they state their profession. In this regard, opinions are also clearly split into two groups: those who are inclined not to tell and those who have no problem telling when asked: *"(…) I don't feel bad because I'm paying; maybe if the exam was free I would because maybe they would talk about me. But I imagine that they're more interested in making money than in other people's lives" (FSW).* Again, there are examples to illustrate this: some FSWs who identified themselves as such were treated very rudely when they took the test. However, this cannot be identified as a general pattern of response in private laboratories. It's important to remember that many of these women seek private services for other health problems, for example prenatal care or other illnesses, and do not need to identify themselves as sex workers. They feel they receive good care, perhaps because they identify themselves in the same way as any other user and not as a FSW.

Finally, the two groups of FSWs agreed on one observation regarding the treatment they receive from private providers. While some people interviewed said that private services must treat clients well in return for the payment they receive, clients should also be treated well because they are people who have money. They thus associate the motive for good treatment with the fact that everyone who requests services has money and therefore deserves to be treated well.

COUNSELING

FSWs and MSM said that orientation or counseling is not usually offered in private facilities, but they cannot actually explain what counseling is. The FSWs, for example, refer to it as "the talk". The majority of FSWs and MSM said they were asked for informed consent.

Those who are familiar with public and NGO services compared them and then realized that they had received counseling in these services. Even though they do not clarify what it involves, we can deduce that they perceive a difference, with private services being inferior to public services: *"In the Health Center, yes. When you go they give you a talk. Then when you go again to get the results, they give you another talk" (FSW).* Pre-test counseling is not often mentioned among PLWHA.

TEST

It is common for FSWs and MSM to get tested every three months, whether it is suggested to them or is their own initiative; this regular testing gives FSWs the confidence to continue working. For FSWs, the test is required both by the owners of the places they work and by the Ministry of Health. In some places they must even go to the police station to have their negative HIV result validated: *"Every time the immigration people come, the Ministry of Health comes and they ask you for your booklet with your exam inside" (FSW).*

It should be mentioned that FSWs frequently move to different cities or even to different countries. In the interviews they make reference to test experiences they have had in other cities in the country, always alternating between private and public services depending on what is accessible in their area and what resources they have at the time. Some have taken advantage of the "disease prevention days" held by some laboratories that do the test at a lower cost.

In respect to PLWHA, many received their first diagnosis after being tested in a private clinic, and their experience was negative; this was mainly due to a lack of information and, in some cases, to poor treatment when they were given the result. Some people in this group commented that if they had known about places like Proyecto Vida, they would have taken the test there. However, they found out about other options through the doctors they saw in the private laboratories.

POST-TEST

Where FSWs received post-test counseling, it consisted of the staff recommending that they continue with their protection methods.

For PLWHA, their experience with post-test counseling is of particular interest because their result was positive. Other target groups (FSWs and MSM) who are HIV negative may have friends or know others who have been given a positive result without counseling or psychological support and have witnessed the emotional reaction this caused: *"I felt empty, I couldn't find anyone to talk to; because I tried to commit suicide. But thank God that they have kept that memory alive, and that's why I'm moving forward and now support several people" (PLWHA).*

PLWHA sometimes are subject to inappropriate treatment by doctors and other health workers when they are given a positive result. Respondents spoke of two people, one a participant in the group, who were physically assaulted (slapped in the face) when they received their result and were blamed and mistaken for FSWs. In another case, staff talked to the woman's husband and recommended that he leave her since she was HIV positive and would soon die: *"I recommend that you leave her because you're very young and she's going to die soon" (PLWHA).* In other cases, the results were given to family members or other acquaintances in an unsealed enveloped. In some instances the test result was associated with withholding documents and passed through various services within the clinic. This experience reveals the stigma these groups face.

It is apparent that when these groups receive an HIV positive diagnosis they do not know what it means or what implications it will have for their health and their lives. The information they receive at that time is limited to an orientation regarding other facilities where they can continue their care. During the study, many mentioned the emotional crisis they went through when they were given the news without sufficient information, with reactions that included suicide attempts or rejection from family members. There are many stories of people who suffered disastrous consequences due to their diagnosis. Thus, the rejection and disrespect of the health provider who gave them the result is added to that of the people around them.

As a result of this experience, many of these people have become voluntary counselors who orient and support people in similar circumstances. The training they have received over time has allowed all of them to confirm that they were not given the necessary counseling when they needed it: *"Now we know that they discriminate, because discrimination is distancing yourself from someone, isolating them, stigmatization is the signal" (PLWHA).*

REQUEST FOR CONFIRMATION TEST

FSWs and MSM did not mention getting a confirmation test. In contrast, most PLWHA reported taking one or more confirmation tests, often of their own volition as a part of the process of disbelief when faced with the diagnosis.

RECOMMENDATIONS FOR HEALTH WORKERS

When asked what private clinic and laboratory staff should know and do to provide better care, the users most commonly stated that staff should be thoroughly trained in everything related to HIV and available to give the necessary information in the proper way and at the right moment. Many of the recommendations are aimed at treating people with HIV with more dignity.

PROVIDERS VS. USERS

The purpose of this table is to establish a dialogue between the two broad groups studied – providers and users – on a variety of points that each group raised, some of which are confirmatory and others contradictory (Table 2). For a more analytical reading of this table we recommend keeping in mind the providers' opinions of clients discussed in section 3.2.2.

TABLE 2. PERSPECTIVES OF PROVIDERS VS. USERS

Providers	Users
Treatment	
Some say that since it is a private service, clients cannot be treated poorly because they are paying customers. In addition, some say that as long as MSM or FSWs are unrecognized as such, there is no problem, but when they are recognized they damage the reputation of the facility and make other users uncomfortable.	Some think their appearance should not matter and that poor treatment in private facilities should not be allowed since they are paying for the service and have the right to demand good treatment. However, some have perceived different treatment due to their appearance. Several FSWs find that some laboratories charge them more because they are perceived to be "women who make easy money". Some PLWHA consider a provider's lack of attention when giving positive results as poor treatment since it demonstrates that their priority is to bill another service, not care for people.
When asked if they accept FSWs, providers respond that they do not know if they are serving this population or not.	FSWs say that when they request private services, it is not necessary to identify themselves as sex workers but rather that they identify themselves in the same way as any other female user.
Pre-test counseling	
Providers use the term "counseling" indiscriminately to refer to information, obtaining consent and brief assessment, not to a risk assessment where they discuss in detail the patient's possible form of exposure and the level of risk he/she may face.	FSWs and MSM state that the counseling they receive does not clarify their doubts or allow them to identify the risks they face. When compared with their experience with counseling received in the public sector, they find that private sector counseling is notably poorer.
Test	
Some provider groups explain that in their workplace, an HIV test is not required prior to surgery. Instead, all patients are treated as if they are HIV positive. With respect to prenatal care, some say they would like the test to be routine, but that it depends on the patient and whether they give consent. The test thus seems to be optional rather than a requirement.	The reasons mentioned most frequently for taking the test were that it was a requirement for surgery and for prenatal care.
Some laboratories point out that they have agreements with the public health system and offer preferential rates to people referred by the public sector.	Several of the FSWs use private services, sometimes referred by the public sector, and pay a special rate that is not the laboratory's usual rate. The PLWHA refer to it as a "disease prevention day". One female PLWHA who is not a FSW commented with respect to her experience in attending this disease prevention day that some health providers (doctors and reception staff) give discriminatory treatment since they confuse non-FSW women with the FSWs who go on these days and insult or attack them, as in her case.

Post-test orientation	
When patients are HIV positive, biochemists and doctors say they refer them to specialized facilities for further care.	PLWHA remember not having received adequate counseling, but rather information regarding other places where the implications of an HIV positive result would be explained to them and where they could also receive treatment.
Several doctors consider counseling to be emotional support in these circumstances.	Some PLWHA indicate that the initial counseling received in some laboratories consisted of calming them emotionally, cheering them up and offering information about an NGO to begin treatment.
Request for confirmation test	
Some laboratories report offering different options for confirmation tests according to the patient's budget, whether ELISA, antibody tests or Western Blot (the last a protein test that is generally used for confirmation and is more expensive). It is difficult to be certain, but it is possible that a patient may undergo more than one "confirmation" test in this process if the initial test is an ELISA, and whether by design or not, a profit is made from this patient in their effort to obtain a definite confirmation.	PLWHA requested and underwent one or more confirmation tests, including rapid tests, as part of the process of disbelief when faced with the diagnosis.
Training recommendations	
Providers expressed different training interests since clinic and laboratory staff members said they did not receive any information about HIV in school. Other participants speak of the need for training in prevention in the workplace and working with HIV patients. They also mention basic HIV training in general. The need was also noted to refresh providers' knowledge of prevention of infection, as well as to give a general picture of the status of the epidemic in Guatemala.	Staff who have extensive training in all aspects of HIV, who are available to offer the necessary information in the proper way and at the right time. Staff who give advice or counseling about HIV and recommendations as to how to prevent it. To treat people with HIV with more dignity.
Some doctors report the need for training to make the private sector aware of topics such as discrimination, stigma, PLWHA, FSWs and MSM, since this is only offered in the public sector. Other interviewees also showed interest in training that addresses stigma, and considered it important to learn more about this topic.	Training in dealing with the homosexual population. Certification of clinics that have the knowledge and quality needed to care for these groups.

4. CONCLUSIONS

With respect to **Objective 1**, private providers in clinics and laboratories have different levels of **knowledge and practices** regarding HIV. Doctors and biochemists are the most knowledgeable staff. Clinic staff are less informed and more afraid of becoming infected. **Counseling** is not identified as a consistent practice and lacks a standard protocol. In the case of positive results, biochemists are the ones who most frequently offer counseling, although no group in the target population specifies what this counseling involves. Laboratory staff (particularly biochemists) pointed out that the vast majority of doctors are not familiar with **HIV testing** procedures and that many people arrive at the laboratory misinformed. The laboratories do not identify themselves as specialized testing facilities, however, the frequency with which users request the test makes it a usual and preferred service for users and providers.

With respect to training needs, family doctors in areas outside the capital may need more current information regarding HIV prevention. It is important to point out that a large part of the laboratory and clinic staff interviewed said they were not given information on this subject during their academic education.

With respect to **Objective 2**, little stigmatization of the target population by private providers was directly identified. Staff often see these groups without noticing their sexual orientation since they do not stand out. However, **stigma and discriminatory treatment** is identified indirectly, in terms of staff referrals to other private facilities or their opinions about these groups. This is also expressed by not accepting these populations as clients or, as the clients themselves pointed out, by not giving them adequate information in the case of a positive result. It even takes the form of giving results in a confrontational manner, discrediting their lifestyle and sexual preference.

With respect to **Objective 3**, a significant number of FSWs and MSM consider themselves responsible for the **treatment** they receive since their appearance reveals their profession and/or sexual identity. Some FSWs prefer to hide their trade to avoid poor treatment, while MSM do not return to facilities where they felt uncomfortable due to explicit mistreatment.

Some FSWs and MSM regard the orientation they received in private facilities not so much as **counseling,** but rather as a "talk" that often left them with doubts about prevention methods.

A large proportion of the PLWHA were given their first HIV-positive diagnosis in a private facility. Private providers thus play an important role in announcing results to clients. However, the majority of providers limit themselves to giving information about NGOs or public hospitals that can offer further support and treatment. This was sometimes done without respecting the client's confidentiality or was accompanied by physical aggression and personal insults. From their experience in the years following their HIV diagnosis, PLWHA feel that they were stigmatized by the private laboratory, including not being given adequate information regarding the meaning of their condition to calm them emotionally and give them hope for recovery. The results of this study thus confirm the important role that the private sector CT services can play in HIV prevention in Guatemala. Additionally, the results demonstrate the need to train providers and raise awareness so that they can offer higher-quality CT services that are more suited to the MARPs.

It is important to remember the limitations of this study with respect to generalizing findings, as with any other qualitative study. The sampling methodology may have been biased, especially in the case of providers. It is possible that those who participated in the study, some of whom participated in the project's training sessions and others who were referred by the former, may have more open attitudes and opinions with respect to FSWs, MSM and PLWHA. Another limitation with providers is the possibility that their responses reflect what they believed to be the "correct" answer that researchers were looking for, although a special effort was made to design open, non-accusatory questions. One limitation of users' responses is that some of the experiences they shared took place several years ago.

ANNEX 1: DATA COLLECTION INSTRUMENTS

DISCUSSION GUIDE FOR FOCUS GROUP WITH USERS (PLWHA)

(Read aloud)
The information that you will share is extremely important to us.
We would thus appreciate your cooperation in observing the following ground rules:

- **We will all turn off our mobile phones.**
- **If someone wishes to speak they will raise their hand to indicate that they wish to make a comment on the topic.**
- **When someone is speaking, the rest of us will listen in silence without making comments among ourselves.**
- **Finally, please speak in a loud voice so that we can record your opinion; we want to include the opinions of everyone in the group.**
- **Thank you very much again for your cooperation.**

1. Before your first positive HIV test, had you taken tests with negative results? What motivated you to take the HIV test (e.g. a broken condom, a doctor's request, a company requirement)?

2. What kinds of private services had you used for HIV testing (that is, NGOs, private clinics, private laboratories, etc.)?

3. What are some of the reasons that you took HIV tests in a private facility instead of a public one? (Inquire about the differences with public hospitals [e.g., cost, quality, waiting time, etc.], what they like most about private clinics, what they like least.)

4. What kind of experience did you have in the private clinics or labs when you took the HIV test?

   - Did you ask for the test yourself or did a doctor ask for it?
   - Were you given pre- and post-test counseling? About what?
   - Were you asked for consent before taking the test?
   - Did you take a confirmation test after the first positive result?
   - Were you referred to other treatment and support services?

5. Where were you given your positive HIV result (that is, in a private clinic, NGO, private lab or health center)?

   - For those who say it was in the private commercial sector: How were you treated by the staff that gave you the positive result?

6. What should private clinic and lab staff know and do in order to give you better care?

Inquire:

Do they have any recommendations about what kind of counseling private providers should offer them (e.g., how to reduce the risk of transmission, how to negotiate the use of a condom, what a negative or positive result means, etc.)?

DISCUSSION GUIDE FOR FOCUS GROUPS WITH FEMALE USERS (FSW)

(Read aloud)
The information that you will share is extremely important to us.
We would thus appreciate your cooperation in observing the following ground rules:

- **We will all turn off our mobile phones.**
- **If someone wishes to speak they will raise their hand to indicate that they wish to make a comment on the topic.**
- **When someone is speaking, the rest of us will listen in silence without making comments among ourselves.**
- **Finally, please speak in a loud voice so that we can record your opinion; we want to include the opinions of everyone in the group.**
- **Thank you very much again for your cooperation.**

1. Have you ever taken an HIV test in a private clinic or laboratory?

2. What kinds of places have you gone to for an HIV test (that is, NGOs, private clinics, private labs, etc.)?

3. What motivated you to take the HIV test? (e.g., when a condom broke, a doctor's request?) If you take the test regularly, how often do you do it?

4. What are some of the reasons you seek private instead of public services? (Inquire about the differences with public hospitals [e.g., cost, quality, waiting time, etc.], what they like best about private clinics, what they like least.)

5. What was the process the last time you took a test in a private clinic or lab?

   - Did you ask for the test yourself or did the doctor suggest it?
   - Were you given pre-test counseling? About what?
   - Were you given post-test counseling? About what?
   - Were you asked for consent before taking the test?
   - Were you referred to treatment and support services in the case of a positive test?

6. How have you been treated by staff in the private clinics and labs where you have taken the test?

7. How do private clinic and lab staff react when they find out or suspect that you are sex workers? How do you feel? (Inquire about the reactions of doctors, nurses, assistants, secretaries, other patients in the clinic, whether the care they receive changes.)

8. What should private clinic and lab staff know and do in order to give you better care? Why?

Inquire:

Do they have any recommendations about what kind of counseling private providers should offer them (e.g., how to reduce the risk of transmission, how to negotiate the use of a condom, what a negative or positive result means, etc.)?

DISCUSSION GUIDE FOR FOCUS GROUP WITH MALE USERS (MSM)

(Read aloud)
The information that you will share is extremely important to us.
We would thus appreciate your cooperation in observing the following ground rules:

- **We will all turn off our mobile phones.**
- **If someone wishes to speak they will raise their hand to indicate that they wish to make a comment on the topic.**
- **When someone is speaking, the rest of us will listen in silence without making comments among ourselves.**
- **Finally, please speak in a loud voice so that we can record your opinion; we want to include the opinions of everyone in the group.**
- **Thank you very much again for your cooperation.**

1. Have you ever taken an HIV test in a private clinic or laboratory?

2. What kinds of places have you gone to for an HIV test (that is, NGOs, private clinics, private labs, etc.)?

3. What motivated you to take the HIV test (e.g., when a condom broke, a doctor's request)? If you take the test regularly, how often do you do it?

4. What are some of the reasons you look for private instead of public services? (Inquire about the differences with public hospitals [e.g., cost, quality, waiting time, etc.], what they like best about private clinics, what they like least.)

5. What was the process the last time you took a test in a private clinic or lab?

   - Did you ask for the test yourself or did the doctor suggest it?
   - Were you given pre-test counseling? About what?
   - Were you given post-test counseling? About what?
   - Were you asked for consent before taking the test?
   - Were you referred to treatment and support services in the case of a positive test?

6. How have you been treated by staff in the private clinics and labs where you have taken the test?

7. How do private clinic and lab staff react when they find out or suspect that you are an MSM? How do you feel? (Inquire about the reactions of doctors, nurses, assistants, secretaries, other patients in the clinic, whether the care they receive changes.)

8. What should private clinic and lab staff know and do in order to give you better care? Why?

Inquire:

Do they have any recommendations about what kind of counseling private providers should offer them (e.g., how to reduce the risk of transmission, how to negotiate the use of a condom, what a negative or positive result means, etc.)?

IN-DEPTH INTERVIEW GUIDE FOR PRIVATE DOCTORS

TOPIC: Differences between the private and public sectors

1. *If they work in sectors other than the private clinic:* **What are some of the differences between working in the private clinic and in other places?** *(Inquire about the work environment, clinical behavior with patients, how patients are treated, the doctor's priorities in each environment.)*
2. What do you like most and least about working in each sector?

TOPIC: Knowledge of HIV/AIDS and its transmission

3. In terms of HIV, what forms of transmission do you know of?
4. What methods do you know of to prevent the transmission of HIV?

TOPIC: Practices used in the process of counseling and HIV testing

5. What HIV-related services do you offer in your clinic? To whom do you offer them? *(Ask whether they offer voluntary HIV testing with pre- and post-test counseling, and what types of patients normally use these services.)*
6. What process is used to carry out the HIV test in your laboratory? (*Ask them to describe the entire process from the moment the patient arrives and requests the test until they are given the test results, as well as the following questions.*)
    - *Under what circumstances do you request the test (with what kind of patients)?*
    - *What kind of counseling is offered to the patient before the test, and about what aspects?*
    - *Where do you test the patient?*
        - *How long do the results take and how do you obtain them?*
    - *Do you offer post-test counseling even in the case of negative results? About what aspects?*
7. Is this a set process or does it vary depending on circumstances or other factors? What are

they (e.g. the patient's appearance, occupation, level of education, state of health)?

8. Where would you refer a patient who tests positive for HIV?

TOPIC: Work-related risk of HIV exposure

9. As a doctor, what risk of HIV infection do you face? Why? (Inquire about work-related risk.)
10. What prevention measures are you familiar with and do you use in your clinic? Does this vary depending on the circumstances?

TOPIC: Attitudes toward at-risk populations

11. In this country, which populations are most affected by HIV? Why do you think these groups are the most affected by HIV?
12. What do you think of FSWs? What do you think of MSM? What do you think of people living with HIV?
13. What percentage of people of whom you request the HIV test in your clinic are FSWs? What percentage are MSM? What percentage are members of the general population?
14. **If users of your clinic identify themselves as MSM or FSWs, or if you suspect they are, how does this change the way they are treated in your clinic?** *(Inquire about prevention measures, changes in mood. Ask if the care process changes in any way and for what reasons.)*
15. We have learned that some people such as FSW and MSM prefer not to visit private medical clinics. Why do you think this occurs? Where do you think they go and why?
16. *If they work in other sectors as well as the private clinic:* **How do you feel about offering services to FSWs and MSM in your other work environment (hospital/health center, social security center or NGO)?** *(Inquire as to whether there are differences in their point of view regarding seeing this population in their private clinic versus in another environment.)*
17. Do you think there are prejudices/stigma and discrimination against MSM and FSWs in private clinics? Can you describe some examples?

TOPIC: Recommendations to improve the quality of care

18. Do you think it is necessary to make changes in your clinic to reduce stigma and discrimination towards MSM and FSWs?
    1. What changes?

    2. What are the greatest barriers to change and how can they be overcome?

    (Inquire about specific recommendations, e.g. staff training, community education campaigns, policy changes.)

19. Have you ever had training in offering HIV services? If yes, who or what organization/agency gave the training? *(Inquire about the topics covered in the training, e.g. counseling and voluntary HIV testing, prevention measures, the rights of PLWHA, etc.)*

    1. Would you recommend this training to a colleague? Why or why not?

IN-DEPTH INTERVIEW GUIDE FOR BIOCHEMISTS

TOPIC: Differences between the private and public sectors

1. *If they work in sectors other than the private laboratory:* **What are some of the differences between working in the private laboratory and in other places?** *(Inquire about the work environment, clinical behavior with patients, how patients are treated, the doctor's priorities in each environment.)*

2. What do you like most and least about working in each sector?

TOPIC: Knowledge of HIV/AIDS and its transmission

3. In terms of HIV, what forms of transmission do you know of?

4. What methods do you know of to prevent HIV transmission?

TOPIC: Practices used in the process of counseling and HIV testing

5. What process is used to carry out the HIV test in your laboratory? (*Ask them to describe the entire process from the moment the patient arrives and requests the test until they are given the test results, as well as the following questions.*)
    - *How does the patient normally arrive (on their own or referred by a doctor)?*
    - *What kind of counseling is offered to the patient before the test, and about what aspects?*
    - *Where do you test the patient?*
        - *How long do the results take and how do you obtain them?*
    - *Do you offer post-test counseling even in the case of negative results? About what aspects?*

6. Is this a set process or does it vary depending on the circumstances or other factors? What

are they (e.g. depending on the patient's appearance, occupation, level of education, state of health)?

7. Where would you refer a patient who tests positive for HIV?

TOPIC: Risk of work-related HIV exposure

8. As a biochemist, what risk of HIV infection do you face? Why? (Inquire about work-related risk.)

9. What prevention measures are you familiar with and do you use in your laboratory (e.g. if you prick yourself with a used needle)? Does this vary depending on the circumstances?

TOPIC: Attitudes towards at-risk populations

10. In this country, which populations are most affected by HIV? Why do you think these groups are the most affected by HIV?

11. What do you think of FSWs? What do you think of MSM? What do you think of people living with HIV?

12. What percentage of people of whom you request the HIV test in your clinic are FSWs? What percentage are MSM? What percentage are members of the general population?

13. **If users of your laboratory identify themselves as MSM or FSWs, or if you suspect they are, how does this change the way they are treated in your laboratory?** *(Inquire about prevention measures, changes in mood. Ask if the care process changes in any way and for what reasons.)*

14. We have learned that some people such as FSWs and MSM prefer not to visit private medical clinics. Why do you think this situation occurs? Where do you think they go and why?

15. *If they work in other sectors as well as the private laboratory:* **How do you feel about offering services to FSWs and MSM in your other work environment (hospital/health center, social security center or NGO)?** *(Inquire as to whether there are differences in their point of view regarding seeing this population in their private laboratory versus in another environment.)*

16. Do you think there are prejudices/stigma and discrimination towards MSM and FSWs in private laboratories? Can you describe any examples?

TOPIC: Recommendations to improve the quality of care

17. Do you think it is necessary to make changes in your laboratory to reduce stigma and

discrimination towards MSM and FSWs?

    1. What changes?
    2. What are the greatest barriers to change and how can they be overcome?

    (Inquire about concrete recommendations, e.g,. staff training, community education campaigns, policy changes, etc.)

18. Have you ever had training in offering HIV services? If yes, who or what organization/agency gave the training? *(Inquire about the topics covered in the training, e.g., counseling and voluntary HIV testing, prevention measures, the rights of PLWHA, etc.)*
    1. Would you recommend this training to a colleague? Why or why not?

DISCUSSION GUIDE FOR FOCUS GROUP WITH HEALTH PROVIDERS (CLINICS AND LABORATORIES)

(Read aloud)
The information that you will share with us is extremely important.
We would thus appreciate your cooperation in observing the following ground rules:

- **We will all turn off our mobile phones.**
- **If someone wishes to speak they will raise their hand to indicate that they wish to make a comment on the topic.**
- **When someone is speaking, the rest of us will listen in silence without making comments among ourselves.**
- **Finally, please speak in a loud voice so that we can record your opinion; we want to include the opinions of everyone in the group.**
- **Thank you very much again for your cooperation.**

1. What HIV-related services does your clinic/laboratory offer? Do users request the test or do you offer it to them? Who do you offer it to and who requests it proactively?

2. What forms of HIV transmission are you familiar with?

3. What methods do you know of to prevent HIV transmission?

4. Are you familiar with the HIV testing process in your clinic/laboratory? (Ask them to describe the whole process from the moment the patient arrives and requests the test until the test results are ready.)
    1. Do you offer voluntary HIV tests with pre- and post-test counseling? When you offer counseling to users, what topics do you cover?
    2. Is this a set process or does it vary depending on the circumstances or other factors? What are they?

5. What are the steps to obtain informed consent from patients before giving them an HIV test? In your experience, are there circumstances under which it is not necessary to obtain the user's consent before giving them the test? Like what?

6. As health workers, what risk of HIV infection do you face? *(Consider whether it is work-related risk or personal risk.)*
    1. What prevention measures are you familiar with and do you use in your clinic? Do they change depending on the circumstances?
7. In this country, what populations are most affected by HIV? Why do you think these groups are the most affected by HIV?
8. What do you think of FSWs? What do you think of MSM? What do you think of people who live with HIV?
9. In your experience, what is the percentage of FSW users who take an HIV test in your clinics/laboratories? What is the percentage of MSM?
10. If users identify themselves as MSM and FSWs, or if you suspect that they are, how does that change the way they are treated in your clinic/laboratory? *(Inquire about prevention measures, changes in mood. Ask if anything changes in the care process and for what reasons.)*
11. We have learned that some people like FSWs and MSM prefer not to visit private clinics and laboratories. Why do you think this occurs? Where do you think they go and why?
12. Do you think there are prejudices/stigma or discrimination towards MSM and FSWs? Can you describe any examples? Do you think there are any prejudices/stigma or discrimination towards MSM and FSWs on the part of health providers in general?
13. Do you think it is necessary to make changes in the clinic/laboratory to reduce the stigma and discrimination against FSWs and MSM? What changes?